US family fights for son to die

A Minnesota family's decision to stop medical treatment of their son has erupted into a public battle over the rights of disabled people in the United States. Jamie Butcher was 17 when a car crash left him unconscious in October 1977. Five years later Ronald Cranford, a neurologist from Minneapolis, diagnosed Jamie as being in a persistent vegetative state.

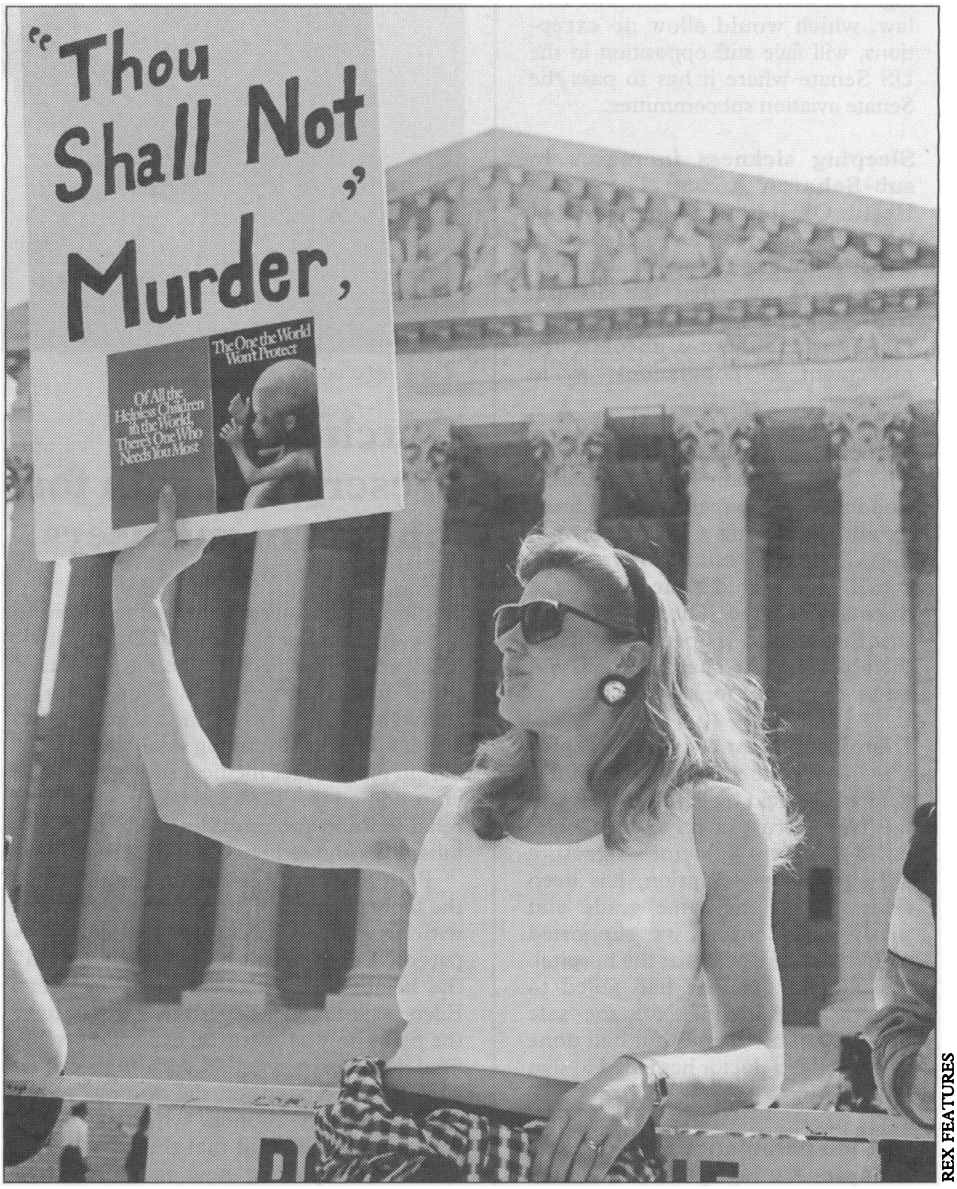
The Butcher family continued to care for Jamie, first for seven years at home and then in a nursing home. This year, almost 17 years after the accident, his mother, Pattie Butcher, announced that the family had decided that Jamie would never regain consciousness, and they asked doctors to remove his feeding tube.

The family contacted Dr Cranford, an expert in the persistent vegetative state, and went through standard procedures to assess whether this was the best course of action for Jamie. The procedures included a neurological re-evaluation, consultation with an ethics committee, and further family discussions. Unlike many states, Minnesota generally leaves patients, families, and their doctors to decide when to withdraw treatment.

Dr Cranford said that he had no reason to think that Jamie's case would cause a legal problem. But the local prosecutor was concerned about a state law that was designed to protect the rights of so called "vulnerable adults"—those who might be unfairly treated because of some disability. The courts quickly decided that because Jamie was in a persistent vegetative state he could not be classed as vulnerable and that he had loving parents to protect him.

But at the last minute two groups that represent disabled patients asked the courts to reconsider and to appoint an unrelated guardian to represent Jamie's "best interests." The state court may rule this week, and Dr Cranford is confident that the family's wishes will prevail. But he and others fear that the case may be the first of many. "These 'pro-life' advocates have been losing ground in the US Supreme Court on the abortion issue, so what we're seeing is a turn toward more violence, such as the murder of two doctors at a Florida abortion clinic and cases like this one, involving decisions at the other end of life," said Dr Cranford.

Jane Hoyt, the leader of those groups opposing the withdrawal of treatment, says that patients in a persistent vegetative state are vulnerable and that suffering families may not be the best people to decide what is in these patients' best interests.



REX FEATURES

'Pro-life' advocates are turning their attention from abortion to decisions at the other end of life

About 14 000 Americans are believed to exist in a persistent vegetative state. Federal courts have given each state the power to choose its own course regarding these patients, and many have chosen to make it difficult for families to stop medical treatments. It was thus ironic that Minnesota, considered to be one of the most liberal states, found itself in a legal bind over a law meant to protect vulnerable patients (such as those who are mentally ill) and to ensure them "food, shelter, clothing, and health care."

A similar law exists at federal level: the Americans with Disabilities Act, which ensures that disabled people will not be "unfairly discriminated against." Legal experts disagree about definitions, but many say that "disabled" means to have limits, and that a person has to have some awareness of those limits to qualify as being disabled. Patients in a persistent vegetative state have no awareness.

"It is these well-meaning laws that now are being turned around and misapplied in the courts by the 'pro-lifers,'" said Dr Cranford. He said that these patients did not have "interests" to protect since they had no working cerebral cortex.

Most of them had families who were willing to make painful decisions quietly among themselves. "But now they are being thrust into the public and legal arenas by 'pro-life' lawyers and advocates," he said. Although only a handful of cases have arisen similar to Jamie Butcher's, Dr Cranford expects many more.—JOHN ROBERTS, North American editor, *BMJ*

US plans to ban smoking on international flights: The US House of Representatives has voted to ban smoking on all international flights to and from the US. The new law, which would allow no exceptions, will face stiff opposition in the US Senate where it has to pass the Senate aviation subcommittee.

Sleeping sickness increases in sub-Saharan Africa: The World Health Organisation reports that at least 250 000 people are carriers of trypanosomiasis (sleeping sickness). The WHO says that the disease, transmitted by the tsetse fly, spreads rapidly where there is uncontrolled movement of populations, as in Rwanda.

Masons' hospital may be sold: The Royal Masonic Hospital in west London, which is registered as a charity and was losing £2m a year until the Charity Commissioners intervened, will be sold if the majority of freemasons agree. The receiver says that the hospital is operating outside the objects of the charity, which was set up to provide for sick masons.

Dismissed nurse is reinstated: Mrs Patricia Cooksley, a British nurse who was sacked by Plymouth Hospitals NHS Trust in July because she failed to obtain a doctor's signature on a repeat prescription, has been reinstated at the same grade and salary. Mrs Cooksley was supported by nurses and doctors at the hospital. She agreed that she had failed to adhere to guidelines for the safe handling of medicines but had done so only after a doctor has failed to sign for the drugs.

London ambulance service near collapse: A study by the GMB union says that the London ambulance service is on the brink of collapse and that morale among the 1700 staff is low. The report follows the government's announcement of an inquiry into delays that led to the death of an 11 year old girl who waited almost an hour for an ambulance.

Surgeon's patients face hepatitis test: Over 700 patients in northern England and Scotland are being recalled for tests after a trainee surgeon who came to Britain from Nigeria three years ago was found to be suffering from hepatitis B. A year ago the Department of Health set a deadline of last June for all surgeons to be vaccinated.

SIMON SHEPHEARD/IMPACT

Heroin addict in Amsterdam

Dutch plan to prescribe heroin for long term misusers

Doctors are planning to prescribe heroin to a few drug misusers in several Dutch cities. They argue that people who have misused drugs for, in some cases, over 20 years should be regarded as having a chronic medical condition. Prescribing small amounts of heroin daily under medical supervision and on condition that the users take part in social rehabilitation programmes could help stabilise lives and reduce suffering, they argue.

Politicians are keen to find solutions to the increasing problem of crime associated with drug misuse. At a national debate as part of "European week of drug prevention" the health minister, Professor Els Borst-Eilers, said that her department would fund the plans only as "medical experiments." A final decision on whether such trials can go ahead will be based on the findings of the health advisory council, which is due to report soon. She said that there should be space for exploring new ideas but that health, not fighting crime, must be the starting point. Heroin could be medically prescribed to only a few so called "hopeless cases," she said, and these people were not the main perpetrators of crime.

The Royal Dutch Medical Association is "extremely reticent" and has reissued strict guidelines first drawn up in 1985. It is concerned that drug misusers will be unable to give informed consent to take part in a trial. It says that prescribing drugs for misusers to take away and inject elsewhere is "medically irresponsible."

Local public health departments have different plans. Amsterdam, which has led drug policy in the past, envisages misusers being prescribed daily low doses of heroin, which they could then inject at home. Dr Gist van Brussel, who sits on the health advisory council, is aiming at helping a specifically defined group of misusers who may have taken drugs for up to 20 years, may take cocaine as well as heroin, and may be homeless and have long criminal records. He said: "It is time to recognise there is chronic addiction...a medical condition with no effective cure." Roland Wolters, who is in charge of outpatient drug programmes for the Jellinekcentrum, one of Amsterdam's largest drug agencies, said that trials with up to 100 misusers were planned. Heroin would be prescribed on condition that participants took part in projects to improve their housing, manage their finances, and start some education.—TONY SHELDON, freelance journalist, Utrecht

Europe gets tougher on tobacco

Tobacco companies in the European Union face even tougher measures if they fail to comply with existing legislation requiring clear public health warnings on cigarette packets. Alarmed at reports suggesting that some companies are trying to circumvent current rules by printing the warnings in faint or small print, the European Commission is now examining ways of enforcing labelling laws already on the statute books.

Padraig Flynn, the union's social affairs commissioner, told the ninth world conference on tobacco and health, which was held in Paris this month, "We will bring forward proposals to strengthen the existing measures if this is considered necessary."

Half a million people in the European Union die each year of diseases related to tobacco consumption. Flynn endorsed the use of taxation, pricing policies, and advertising regulations as ways of fighting smoking. He also repeated his support for banning all types of tobacco advertising in the union. Proposals on the table remain blocked by a minority of governments, but senior officials in the commission believe

that support for the ban is increasing.

The European Commission's battle against smoking does not rely on legislation alone. Through its Europe against cancer programmes, the second of which runs out at the end of the year, it has encouraged links between antismoking groups and doctors and scientists across Europe. The cooperation has spawned concepts such as the "no smoking hospitals" network and the "no smoking towns" programme.

EU governments are currently being asked to endorse a third cancer action plan, running from 1995 to 1999 with funding of some 64m European currency units. It will encourage projects to protect vulnerable groups, such as pregnant women and children, from the risks of passive smoking. —RORY WATSON, Brussels correspondent, *European*

Doctor's suicide prompts look at hours

A coroner has recommended a review of the working conditions of all house surgeons in New Zealand after finding that 24 year old Dr Mathew Rowbotham, a first year doctor, committed suicide in April. Whangarei Hospital confirmed after the inquest that Dr Rowbotham had worked 80 hours in the week before his death. The doctor's father, Mr Tom Rowbotham, confirmed that his son had worked such long hours every third week that he was on duty.

Dr Loek Henneveld, the chief medical adviser to Northland Health, the crown health enterprise responsible for Whangarei Hospital, said that a continuing review of the working conditions and hours of junior doctors at the hospital had been brought into sharper focus by the suicide. Three more doctors would be added to the junior doctors' rota at the hospital next year. This would allow the hospital to meet the guidelines of the Medical Council's medical education committee that state that junior doctors should not work by themselves at night or in the emergency department during their first six months. A post can lose its accreditation for intern (first year) training if it does not meet the committee's guidelines.

Dr Henneveld said another improvement—a buddy system suggested by the junior doctors—seemed to be reducing some of the stress. Each first year house surgeon was now paired with a second year doctor. The crown health enterprise had agreed to budget for senior doctors to spend more time with junior staff. There were compelling reasons to try to avoid doctors working such long hours, said Dr Henneveld. Patients' care could suffer, staff welfare was an obvious consideration, and the crown health enterprise was finding it extremely expensive to pay penal rates for such long hours, he said,

Although their contracts vary, junior doctors generally receive up to $NZ1000 (£400) if they work more than 72 hours a week averaged over two weeks or if they do not get an eight hour break after 16 hours on duty.

In less onerous specialties junior doctors may choose to be on call from home for longer periods,or staff shortages may mean that they have to cover for absent colleagues or unfilled posts. In these specialties junior doctors are reluctant to claim the extra money for fear of disapproval by consultant staff. The money is taken from the departments' budgets.

The opposition health spokeswoman, Lianne Dalziel, asked whether it was safe for junior doctors regularly to work 16 hours a day when truck and taxi drivers were limited by law to driving only 11 hours a day. The minister for crown health enterprises, Mr Paul East, said that the issue of junior doctors' working hours was worth considering but that many young doctors were working fewer hours than their counterparts did 10 years ago. Enforcing limits on doctors' hours by statute was not the answer, he said.

Mr East said that he agreed with the chairman of the New Zealand Medical Association, Dr Dennis Pezaro, that the most important factor was that young doctors should speak out when they needed help. Dr Pezaro said that hospitals would not know about the problems if they did not hear about them. "One of the dangerous features of this tragedy was the feeling of isolation. Shorter working hours will not solve the problem if there is not good communication." Doctors needed to assimilate so much information and experience that shorter working hours would mean that their postgraduate training would lengthen, he said.—CHARLES ESSEX, community paediatrician, Auckland

India considers improving lives of disabled people

The Indian parliament is to consider a bill aimed at improving the lives of the country's 35 million disabled people. The legislation would include the introduction of free education for disabled children and the setting aside of a proportion of government jobs for adults with disabilities.

Efforts to improve India's policies towards disabled people have been going on since 1981—the international year of the disabled. But so far only a tenth of disabled people are covered by existing rehabilitation services. This latest set of proposals would provide disabled children with special school books and equipment, including Braille and low vision aids, hearing aids, and prostheses.Under the new proposals schools with admissions policies that discriminate against disabled children could face cuts in their government grants. The bill also provides for punitive measures against parents who discriminate against disabled children and against anyone who exploits such children for begging.

The bill provides for 4% of government posts to be reserved for disabled people and says that an employee acquiring a disability during service must not be dismissed, given a lower rank, or denied promotion. Employment for disabled people would be their right, not an act of charity. The bill also says that any government official found guilty of exploiting a disabled member of staff would be punished, by demotion or even dismissal.

RODERICK JOHNSON/PANOS

Disabled people could be given the right to employment in India

The primary responsibility for people with disabilities in India currently rests with federal states, with some financial support from central government. The proposed bill suggests a central coordination council instead, to advise on the formulation of policies, legislation, and projects and to coordinate the overall rehabilitation programme. Federal states would have similar councils.

Schemes already in existence include scholarships for disabled students, incentives for employers who take on people with disabilities, and the reserving of a proportion of certain categories of government posts for disabled people.—ZAKA IMAM, doctor and writer, Lucknow

France emphasises teaching of general practice

Faced with a steady increase in young doctors choosing to specialise rather than to practise general medicine, the French government is taking measures to develop and improve the teaching of general practice.

Reforms jointly developed by the ministries of health and of education and research provide for compulsory seminars on general practice during the first two years of the medical course. These seminars will cover such topics as the organisation of professional life, health economics, and public health problems such as addiction, gerontology, AIDS, chronic diseases, and the care of physically and mentally handicapped patients. During the next four years more classes will be devoted to diseases of interest to general practitioners, and towards the end of the curriculum a six month residency in a centre of primary health care, most probably in group practice, will be required. This residency will replace the 30 to 50 half day training periods with a generalist.

General practitioners, almost all of whom agree that their practice is neglected in a curriculum that heavily emphasises basic sciences, will participate in the development of teaching programmes, and a budget will be provided to pay for their participation in teaching. At present, there is one general practitioner per medical faculty, usually an associate professor.

The duration of medical studies leading to general practice may thus be increased. Currently, future general practitioners spend two years as hospital residents and the half year residency in primary health care may be added to this. Students who wish to become specialists take a competitive exam at the end of the six years of study, and those who succeed (about two fifths of candidates) continue their studies and internships for another four years. Most of the students who fail this exam turn to general practice, which they had not selected originally and for which they had no specific training at medical school.

The reforms will gradually be applied, beginning next year, at a time when the number of medical students is swelling rapidly. An increasing number of young men and women who have completed secondary education (the baccalaureate) are faced with unemployment and turn to higher education. Medical faculties have been their first choice. In 1993 almost a third more students enrolled in medical faculties than in 1992, and this year the increase is about a quarter over last year. Students are aware that the number of doctors in France will start decreasing in 2010 and that medicine may be a good career opportunity.—ALEXANDER DOROZYNSKI, medical journalist, Paris

MOHAMED ANSAR/IMPACT

The French government is pushing general practice as a career option

Surgeon harassed after sexual misconduct

The case of a surgeon in New Zealand who was found guilty of sexual misconduct by the Medical Council's disciplinary committee but was suspended for only six months has thrown the issue of disciplining doctors under public scrutiny. The surgeon, from Dunedin, was found guilty on four counts related to sexual misconduct against patients.

In June last year he was granted the right not to have his name revealed pending an appeal. The unnamed surgeon returned to work in November, and the appeal procedure was set in motion only after an investigation by the magazine *North and South* was published last month.

The surgeon is due to appear again before the disciplinary committee on 21 November because of further allegations, including rape. His appeal will be heard in the High Court in December. Meanwhile posters have appeared in Dunedin featuring the man's name, medical specialty, and the words "sexual molester."

Dr Robin Briant, chairwoman of the Medical Council, said that the disciplinary committee had been waiting for the High Court to set the appeal process in motion. Dr Briant said that patients would be better off taking complaints of sexual misconduct to the police.

The Medical Council has only limited powers. If a doctor is found guilty by its disciplinary committee the council can impose a fine of $NZ1000, which has remained unchanged since 1968. Doctors can be struck off the medical register or suspended for up to 12 months, or conditions can be imposed on their future practice. The details of each case, including the doctor's name, are then published in the *New Zealand Medical Journal* unless an appeal is lodged.

The Medical Council approached the government eight years ago with proposals to give its disciplinary committee power to hand out greater penalties, but the new Medical Practitioners Act is still awaited. This proposes fines up to $NZ10 000 (£4000) and enforced compliance with requirements such as counselling or further training. Dr Briant has appealed to political parties to accelerate the legalisation, which will allow the council to make the disciplining of doctors more independent and visible. She said that the council would welcome openness in the disciplinary process so that the public and the medical profession could develop informed opinions about its fairness. "It does not support the suppression of names of doctors found guilty of serious offences," she said.

A complementary piece of legislation is the Health and Disabilities Services Bill, which emphasises the resolution of conflicts through mediation, patients' advocates, and a code of rights, which must be in place by 1 July next year.—CHARLES ESSEX, community paediatrician, Auckland

Tories extend general practice fundholding

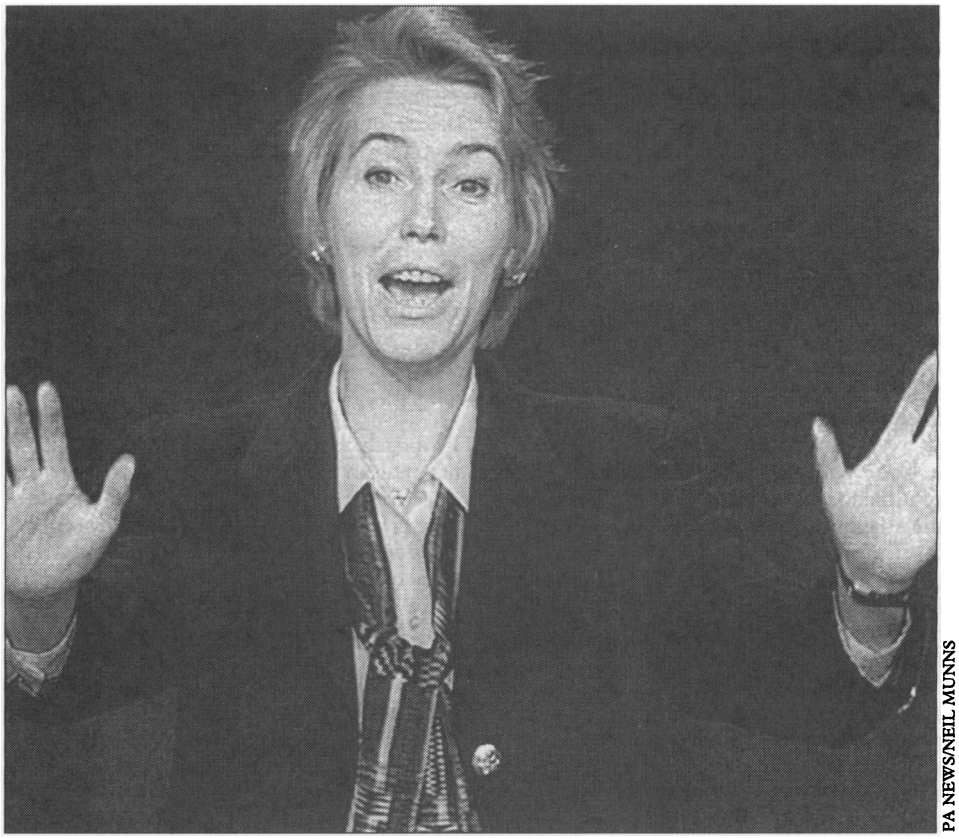
General practices will be able to become fundholders with 5000 patients, Virginia Bottomley, the health secretary, told the Conservative party conference last week (see editorial p1032). Reducing the minimum list size from 7000 will draw in an additional 18% of the population. The government has decided that fundholders will now be able to purchase all elective surgery (with a few rare and high cost exceptions), most outpatient attendances, and a wider range of community health services.

The pilot schemes currently in progress that allow fundholders to buy all hospital and community health services care will be extended to 25-30 practices. There will be a new, easy entry community fundholding scheme, which will be open to all practices with 3000 or more patients, to cover drugs, staff, diagnostic tests, and community health services.

Mrs Bottomley said that the "radical extension of fundholding" would be in place by April 1996. Dr Sandy Macara, chairman of the British Medical Association's council, said that the association would have preferred the government to look at the more imaginative idea of locality purchasing, whereby fundholders, non-fundholders, family health services authorities, and district health authorities combine to produce a purchasing plan for the locality, rather than pursue a scheme that had not had overwhelming support.

The secretary of state promised that procedures would be tightened so that some proof of eligibility would be required by those claiming exemption from prescription charges. It has been estimated that between £20m and £30m a year could be saved.

From next April all NHS trusts will have to set out in their annual reports how much they spend on management alongside the league tables of their performance.—LINDA BEECHAM, *BMJ*



PA NEWS/NEIL MUNNS

Virginia Bottomley: extending fundholding to whoever wants it

European Union tries to control disease

The recent outbreaks of plague in India and diphtheria in eastern Europe and the spread of diseases such as hepatitis have convinced the European Commission that it should extend its existing programme to combat AIDS to cover other communicable diseases. The commission is proposing to spend 50m European currency units over the next five years, encouraging governments in the European Union to implement a comprehensive vaccination programme and improve early detection and screening.

With 105 000 cases of AIDS reported in the 12 member states last March and possibly a further 500 000 people infected with HIV, the fight against AIDS remains one of the union's main public health priorities. But the reappearance of certain infectious diseases is now demanding a response by the union as well as national measures. The commission, in trying to win the support of the governments of member states for its wider strategy, argues: "The resurgence of certain communicable diseases lends weight to the need for a re-examination of vaccination policies used by member states to assist in improving their control."

Vaccination policies vary widely from compulsory vaccination for all or for certain groups to voluntary vaccination with or without incentives such as free vaccines. All member states vaccinate against diphtheria, tetanus, and polio, and most do so against whooping cough, measles, mumps, and rubella. But even then differences remain. On average over 90% of children in the union are vaccinated against whooping cough, except in Greece (84%) and Italy and Ireland (40%). Only Italy, for instance, insists on compulsory vaccination against hepatitis B for the entire country, although almost one million people in Europe are estimated to be affected by the disease every year, of whom 24 000 will die.

The commission acknowledges that responsibility for national immunisation programmes lies firmly with member states. But it argues that the degree of differences among the various programmes and the absence of concise information prevent any clear indication of the level of protection of populations, which is a potential problem when imported cases of a disease appear in a country.

The commission is keen to publish the details of all member states' vaccination schedules in one document, and it also wants to develop a standard method for assessing levels of vaccination, particularly in children.

The new policy would also promote networks within different medical professions to increase surveillance of various communicable diseases. These would be used for the early detection of epidemics, to identify groups at risk, and to evaluate prevention strategies.

The networks could operate through computer links involving doctors and laboratories, interlinking national surveillance systems, and use of one off studies and surveys on a given day.—RORY WATSON, Brussels correspondent, *European*

Pollution in Paris causes problems

Atmospheric pollution by nitrogen dioxide, a byproduct of vehicle exhausts, in Paris and its suburbs increases by 15-20% the number of people who need to be admitted to hospital for asthma A new survey also shows that atmospheric sulphur dioxide, produced mainly by industry and heating, increases mortality from cardiovascular disease by a tenth.

The survey, carried out by the Observatory for Health for Paris and Ile de France (the densely populated region around Paris), examined atmospheric pollution and health indicators since 1987. It

found that a high ozone level seemed to be responsible for an increase of about a fifth in the number of older people with chronic respiratory diseases needing admission to hospital. The results were presented at a meeting at the Eiffel Tower, where a station was installed three months ago to monitor pollutants. The station has confirmed data accumulated by the 60 monitoring stations in and around the city over the past five years. The report confirms "a marked effect produced by increased atmospheric nitrogen dioxide, essentially linked to automobile traffic, on health indicators." Industrial pollution, together with pollution produced by central heating systems, has decreased.

The survey has shown that, as soon as levels of pollution by sulphur dioxide, nitrogen dioxide, and ozone rise 100 $\mu g/m^3$ above the maximum levels said to be acceptable for Europe, health problems beyond the customary sore throats and stinging eyes increase. Since last summer, broadcasts have warned Parisians of high pollution levels.

Michel Darnier, environment minister, said that systematic monitoring of atmospheric pollutants would be extended to other cities within the next few years. He said that antipollution measures would need a reappraisal of urban management and a reduction in the use of cars in cities. He said that he opposed the recent increase in taxes on lead free petrol, which had been sold at lower prices as an incentive to use it. —ALEXANDER DOROZYNSKI, medical journalist, Paris

MPs query closure of military hospitals

Proposals to close two of the three military hospitals in Britain to save defence spending have been criticised by the Commons defence committee. In a report last week the MPs on the committee said that the planned cuts caused them concern and required more detailed justification. They agree with the British Medical Association that civilians should be admitted to military hospitals in peacetime to avoid underuse, and help to reduce NHS waiting lists.

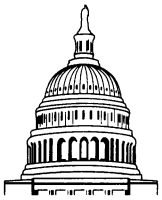
Last July the government's study into defence costs proposed that the Royal Naval Hospital at Haslar, Gosport, should become the single hospital for all three armed services for Britain. Cambridge Military Hospital, Aldershot, and Princess Alexandra Hospital at Wroughton, near Swindon, would close. Military hospital units would be established within three NHS hospitals still to be selected (23 July, p 222).

The defence select committee describes it as remarkable that the ministry now recommends that only 700-800 beds in service hospitals will be needed in Britain instead of the current 1250. The need for reductions has apparently arisen from "developing medical practice" with increased day surgery and because of the perceived advantages of military units located in NHS hospitals. The BMA's evidence to the committee suggests a possible 750 redundancies among uniformed medical staff. It argues that the cuts may well destroy the training base of the medical branches of the armed forces. The BMA adds that the greater the reduction in the fighting forces the more important it becomes to maintain the health of individual service personnel.—JOHN WARDEN, parliamentary correspondent, *BMJ*

The Defence Costs Study, 8th Report of the Defence Committee is available from HMSO bookshops, price £14.40.

Focus: Washington

Trying to do right by health reform



Congressional elections are two weeks away, and Republicans are mildly optimistic that for the first time in half a century they will recapture majorities in both the House and the Senate. Most commentators say that such a change would cripple Bill Clinton's political agenda for the last two years of his term, but a few pundits —Republicans and even Democrats—say that such a "defeat" is Clinton's best chance of reviving health reform in 1995.

The *Wall Street Journal* pointed out that when a Democratic president has a Democratic congress he can ignore the Republican minority. But when the opposition controls the legislature the president must sit down and do some serious negotiating.

Most Republicans and Democrats are genuinely sorry that some kind of reform did not pass in 1994, since they do agree on many issues: ensuring that Americans can carry insurance from job to job, providing for more uniform rates and benefits, and punishing insurance companies that will not cover the chronically ill.

The Clinton administration apparently has seen these opportunities for agreement and is already is regrouping for 1995. Ira C Magaziner, the man who orchestrated the 500 person task force to create the Clinton "Health Security Act," is rumoured to have already been demoted. Clinton's budget directors will lead the next charge. During this year's skirmish the opposition succeeded in portraying the President's plan as too costly, and he is determined to erase that image next year.

He has already unleashed Donna E Shalala, his secretary of health and human services, who was kept off the battlefield in 1994 (as an academic she was considered too politically naive). Last week she wrote an essay in the *Washington Post* that gave 10 reasons why "health reform isn't dead":

(10) Medical inflation still outstrips the cost of living, so that by 2003 one in five dollars will be spent on health care.

(9) By 2003, at present rates, another 4 million Americans will lose their health insurance, bringing the total to 43 million.

(8) Each year fewer employers offer health insurance to their workers, and many others cut benefits.

(7) Because the number of uninsured has risen and because hospitals must care for whomever comes to their doors "cost shifting" (charging insured patients more to cover the uninsured) has risen by more than 50% over the past 12 years.

(6) Medical inflation has slowed only from 3.0% above the general rate to 2.9% in the past year. "That's progress, but not much," says Secretary Shalala.

(5) The medical inflation rate has slowed three times since the second world war, each time when health care reform was seriously debated.

(4) The US government deficit has fallen in each of the past three years in all areas except health care. "If we fail to control those costs, the deficit will explode again," she said.

(3) "Life is a pre-existing condition." The government estimates that 81 million Americans have some chronic problem that would make it difficult or impossible for them to regain medical insurance if they lost their present policies.

(2) Without some reform the marketplace will continue to reward "sick care" over prevention. "How can we continue to ask people to take greater responsibility for themselves if our system continues to be [so] skewed?" she wrote.

(1) Even after the political fiasco of 1994 polls show that 70% of Americans still want some type of reform that guarantees that every citizen can get and keep insurance.

To her colleagues in Congress Secretary Shalala offered Mark Twain's advice for next year: "Always do right. This will gratify some and astonish the rest." Americans seem to be enraged over the failure of Congress to pass some health reform bill in 1994. Their votes in two weeks will largely determine whether they are enraged or astonished this time next year.—JOHN ROBERTS